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DIVISION OF HEALTH

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MEMORANDUM

DATE: January 14, 1997

TO: Physical Therapists
Outpatient Hospitals
Therapy Clinics
Rehabilitation Agencies

FROM: Peggy L. Bartels, Director PLB for
Bureau of Health Care Financing

SUBJECT: Wisconsin Medicaid Provider Handbook, Part P, Division II

Enclosed is the first issue of the Wisconsin Medicaid provider handbook, Part P, Division II, for physical therapy services.

The Wisconsin Physical Therapy Association's Medicaid subcommittee was instrumental in the development of this handbook.

This handbook:

- Compiles in one place the current policies and information from earlier Medicaid provider publications (bulletins, updates and handbook).

- Clarifies Wisconsin Medicaid's existing policies, requirements and limitations for prior authorization and spell of illness; provider certification types for physical therapy; coverage and reimbursement of school-based services (SBS), and the impact of this benefit on non-school Medicaid physical therapists; and communication with other Medicaid providers (including SBS and others).

You will find this handbook helpful in submitting and amending your prior authorization requests, getting your claims paid quickly and efficiently, and in resolving any billing problems you encounter. Please keep the most recent update regarding HCPCS and CPT procedure codes until you receive handbook replacement pages. We will communicate future policy changes through Wisconsin Medicaid Updates and handbook replacement pages.

We appreciate your interest in providing services to Medicaid recipients. Thank you for becoming a Medicaid provider.

PLB:vg
CH09073.CW

Enclosure

Introduction

Read all materials before initiating services to ensure a thorough understanding of Medicaid policy and billing procedures.

Wisconsin Medicaid is governed by the Wisconsin Administrative Code, Rules of Health and Family Services, Chapters HSS 101-108, and by state and federal law. Two parts of the Wisconsin Medicaid provider handbook interpret these regulations. The two parts of the handbook are designed for use with each other and with the Wis. Admin. Code.

Part A, the all-provider handbook, includes general policy guidelines, regulations, and billing information applicable to all types of certified providers. *Part P, Division II,* the service-specific part of the handbook, includes information on provider eligibility criteria, covered services, payment methodology, prior authorization, and billing instructions. The Wisconsin Medicaid Managed Care Guide's provider section includes information on policy guidelines and regulations for AFDC/Healthy Start recipients and the managed care program. Each provider is sent a copy of Part A, the all-provider handbook, the appropriate service-specific handbook, and the Wisconsin Medicaid Managed Care Guide's provider section at the time of certification.

Purchase additional copies of provider handbooks by completing the order form in Appendix 36 of Part A, the all-provider handbook.

When requesting a handbook, be sure to indicate the service provided (e.g., physician, chiropractic, dental). For a complete source of Medicaid regulations and policies, refer to HSS 101-108, Wis. Admin. Code. If there is any substantive conflict between HSS 101-108 and the handbook, the meaning of the Wis. Admin. Code holds. Providers may purchase HSS 101-108 from Document Sales at the address in Appendix 3 of Part A, the all-provider handbook.

There are other documents, including state and federal laws and regulations, relating to Wisconsin Medicaid:

- Sections 49.43 - 49.497, Wisconsin Statutes.
- Title XIX of the Social Security Act and its enabling regulations, Title 42 - Public Health, Parts 430-456.

A list of common terms and their abbreviations is in Appendix 30 of Part A, the all-provider handbook, and in HSS 101, Wis. Admin. Code.

Physical Therapy
Table of Contents

A. Type of Handbook

Part P, Division II, is the service-specific portion of the Wisconsin Medicaid provider handbook. Part P, Division II, includes information about provider eligibility criteria, recipient eligibility criteria, covered services, payment rates, prior authorization, and billing instructions. Use Part P, Division II, with Part A, the all-provider handbook, which includes general policy guidelines, regulations, and billing information applicable to all types of certified providers. Refer to the Wisconsin Medicaid Managed Care Guide's provider section for general policy and regulation information for AFDC/Healthy Start recipients and the managed care program.

B. Provider Information

Provider Eligibility and Certification

General information on Medicaid certification requirements is in Section II of Part A, the all-provider handbook.

Certification Requirements for Physical Therapists (PTs)

For Medicaid certification:

- ✓ PTs must be licensed under ss. 448.05 and 448.07, Wis. Stats., and Med 7, Wis. Admin. Code.
- ✓ PTs who are granted border-status are exempt from the Wisconsin licensure requirement but must be licensed by the appropriate agency in the state in which they practice.
- ✓ PTs with temporary licenses or registrations are eligible for temporary certification. This certification is canceled effective 60 days after the next oral examination is given unless the provider submits proof of a permanent license to Wisconsin Medicaid before that date.

All PTs (other than PTs providing services *exclusively* for a rehabilitation agency, home health agency, school-based services [SBS] provider, or *at a licensed hospital location*) must be individually certified.

Certification Requirements for Physical Therapy Assistants (PTAs)

For Medicaid certification, PTAs must meet and do all of the following:

- ✓ Graduate from a two-year college-level program approved by the American Physical Therapy Association.
- ✓ Provide services under the direct, immediate, onsite supervision of a Medicaid-certified PT.
- ✓ Submit a copy of the PTA transcript.
- ✓ Submit the "Wisconsin Medicaid Declaration of Supervision for Non-Billing Providers."

All PTAs (other than PTAs providing services *exclusively* for a rehabilitation agency, home health agency, SBS provider, or *at a licensed hospital location*) must be individually certified. PTAs cannot be independent providers due to Medicaid supervision requirements. The provider number issued to a PTA is used *only* as the performing provider number on all submitted claims and may *not* be used as a billing provider number.

Note: Claims for services (other than rehabilitation agency, SBS, or *at* a hospital) must be billed with a group billing number or the certified PTA supervisor's provider number. The PTA's non-billing performing provider number must be included as the performer.

B. Provider Information (continued)

Change in Supervision, Employment, or Address for Certified PTAs
When a certified PTA has a change in his/her PT supervisor, the PTA must complete a new "Wisconsin Medicaid Declaration of Supervision for Non-Billing Providers" form. Refer to Appendix 15 of this handbook (or Appendix 34 of Part A, the all-provider handbook) for the supervision form. When a certified PTA also has a change in address or employment, the PTA must complete the "Wisconsin Medicaid Provider Change of Address or Status" form. Refer to Appendix 34 of Part A, the all-provider handbook, for the change of address and status forms. Please photocopy these forms as needed.

Therapists Certified by the Department of Public Instruction (DPI)
Therapists certified by the DPI who do not meet Medicaid's certification requirements are not eligible for individual Medicaid certification. Their services are billable only by SBS providers.

Physical Therapy Aides
Physical therapy aides are not separately certified by Wisconsin Medicaid. Refer to Section II of this handbook for information on physical therapy aide services and limitations.

Certification Requirements for Rehabilitation Agencies
Rehabilitation agencies must meet the criteria in HSS 105.34, Wis. Admin. Code: "For Medicaid certification, a rehabilitation agency providing outpatient physical therapy, or speech and language pathology, or occupational therapy will be certified to participate in *Medicare* as an outpatient rehabilitation agency under 42 CFR 405.1702 to 405.1726."

A rehabilitation agency does all of the following:

- ✓ Provides an integrated multi-disciplinary program of services to upgrade the physical functioning of handicapped, disabled individuals.
- ✓ Brings together a team of specialized rehabilitation personnel to provide these services.
- ✓ Provides services which, at a minimum, consist of physical therapy, speech pathology, rehabilitation program, social, or vocational adjustment services.

Rehabilitation agencies must meet a number of requirements which do not apply to independent therapists. The following is a general description of *Medicare* certification requirements for rehabilitation agencies which providers must meet before receiving Medicaid certification:

- ✓ Have a governing body and a full-time administrator.
- ✓ Have written personnel policies and written recipient care policies.
- ✓ Have a physician available to furnish emergency medical care.
- ✓ Provide social or vocational adjustment services to all recipients in need of such services by making available psychologists, social workers, or vocational specialists (either as salaried employees or on contract).
- ✓ Have certain safety features, such as a fire extinguisher, readily negotiable stairways, and lighting and fire alarm systems (a minimum of two people must be on duty at all times).
- ✓ Meet federal requirements concerning lighting, ventilation, lavatories, and general space regardless of whether these are required by state or local licensure laws.

B. Provider Information (continued)

- ✓ Have an infection-control committee.
- ✓ Have a full-time employee responsible for house-keeping services or must contract for such services.
- ✓ Have a pest-control program.
- ✓ Provide staff training and drills on disaster preparedness.
- ✓ Provide for quarterly review and evaluation of a sample of clinical records by appropriate health professionals.
- ✓ Conduct an annual statistical evaluation of its services.

PTs employed by, or under contract to, rehabilitation agencies are not required to be individually certified by Wisconsin Medicaid (unless they have private patients for whom they bill independently). However, PTs and PTAs employed by, or under contract to, rehabilitation agencies must meet all of the requirements for Medicaid certification. The rehabilitation agency must maintain records showing that they meet these requirements.

Medicaid Certification Process for Rehabilitation Agencies

Providers must apply simultaneously to Medicare and Wisconsin Medicaid for certification as a rehabilitation agency to ensure the effective certification dates coincide. Wisconsin Medicaid must verify the Medicare certification number before a Medicaid provider number is issued. Medicaid therapy group providers considering conversion to the Medicaid rehabilitation agency provider type may contact the fiscal agent. Contact the fiscal agent to obtain the application, obtain more information about the detailed conversion process, and to ensure services are billed appropriately during the conversion process. Refer to Appendix 2 of Part A, the all-provider handbook, for the fiscal agent's Provider Maintenance mailing address and Correspondence Unit telephone numbers.

Before receiving Medicare certification, a rehabilitation agency is surveyed by the Wisconsin Department of Health and Family Services (DHFS) under a contract with the federal Health Care Financing Administration (HCFA). The survey reviews the agency's administration and rehabilitation programs.

Certification for Durable Medical Equipment (DME)

Certified PTs and rehabilitation agencies do not need separate certification as a DME provider to provide the equipment identified in the DME Index as billable by physical therapy providers, or by those therapy groups, clinics, and rehabilitation agencies which include physical therapy. Separate DME certification is required to provide DME that are not identified as billable by these therapy provider types.

All DME policy and billing instructions for certified therapy and DME providers are in the DME and Disposable Medical Supplies (DMS) provider handbook, Part N. All therapy providers receive a copy of Part N. If you want additional copies, request the Part N provider handbook by writing to:

EDS
Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

B. Provider Information (continued)

Types of Medicaid Provider Numbers Issued to Individuals and Organizations Providing PT Services

Individual Performing Provider, Billing

The following applies for a PT who can practice independently:

- ✓ The PT can independently provide services, bill Wisconsin Medicaid directly, and request prior authorization (PA) for the PT's services provided to Medicaid recipients.
- ✓ The PT can bill and request PA for the services of assistants the PT supervises.
- ✓ The PT's Medicaid provider number may be used as a billing number or a performing number.

The individual PTs included are the following:

- ✓ PTs in independent practice.
- ✓ PTs working under contract/arrangements with a nursing home where the PT acts as an individual performing provider (the nursing home's provider number must be used to bill Wisconsin Medicaid and request PA if the claims are to be paid to the nursing home).
- ✓ PTs working for an organization that is required to indicate the performer's number on the claim (the PT's number is used as the performing provider number if a group billing number is used [see next section]).

Individual Performing Provider, Non-Billing

The following applies for an PTA working under the immediate onsite supervision of a Medicaid-certified PT:

- ✓ The PT allows the PTA to provide services to Medicaid recipients. Those services are then billed to Wisconsin Medicaid using the provider number of the PTA's supervisor or clinic along with the PTA's number as the performing provider number.
- ✓ The PTA's Medicaid provider number can be used as a performing number, *not* as a billing number.

The individual PTAs included are the following:

- ✓ PTAs supervised by a Medicaid-certified PT in independent practice.
- ✓ PTAs supervised by a Medicaid-certified PT in an organization required to include the performing provider's number on the claim.

Group Billing Number, Performing Provider Number Is Required

A group billing number is issued as an accounting or billing convenience for groups of individually certified providers. The group billing number allows the group of individuals to do all of the following:

- ✓ Bill Wisconsin Medicaid.
- ✓ Receive one payment for each claims processing cycle.
- ✓ Request PA under the group billing number.

B. Provider Information (continued)

Examples of groups with individually certified providers include the following:

- ✓ *Therapy groups* - Provide two or more types of therapy (e.g., PT and OT or PT, OT, and Speech).
- ✓ *Therapy clinics* - Provide one type of therapy only (e.g., PT or OT).
- ✓ *Nursing home* - PT provided by PT staff employed by, or under contract with, the nursing home; the nursing home's provider number is used as the billing number.
- ✓ *Licensed hospital's off-site services* - Hospital PT staff providing PT services off the licensed hospital site (services cannot be billed as hospital outpatient; they must be billed fee-for-service and include the performing provider number).

Group Billing Number, Performing Provider Number Is Not Required

The following applies for some organizations employing PT staff who meet the Medicaid individual certification requirements (exclude school-based services [SBS] provider's staff) and does not require a performing provider number:

- ✓ The organization may bill Wisconsin Medicaid, receive one payment for each claims processing cycle, and request PA under one provider number.
- ✓ No separate Medicaid certification is required for individual performing providers. However, the Medicaid-certified organization must maintain records documenting that their PTs and PTAs meet Medicaid certification requirements for PTs and PTAs (excludes SBS providers).

Examples of organizations employing PT staff who are not required to obtain a separate Medicaid performing provider number include the following:

- ✓ Rehabilitation agencies.
- ✓ Licensed hospitals (only for services provided at the licensed hospital site; individual certification of staff is required for services provided off the licensed hospital site and claims require the performer's provider number).
- ✓ Home health agencies with PTs providing therapy services.
- ✓ School districts and Cooperative Educational Service Agencies (CESAs) certified as SBS providers; therapy services provided at school must be billed with an SBS provider number. SBS staff must meet DPI certification and licensure requirements, not Medicaid certification requirements.

Scope of Service

The policies in Part P, Division II, govern services provided within the scope of the profession's practice as defined in Section 448.01 (4), Wis. Stats, N 12, Wis. Admin. Code, and HSS 107.16, Wis. Admin. Code. Refer to Section II of this handbook for covered services and related limitations.

Payment Methods

Physical therapy and rehabilitation agency services are paid the lesser of the following:

- ✓ The provider's usual and customary charge.
- ✓ The maximum allowable fee.

B. Provider Information (continued)

The Medicaid maximum allowable fee applies to one treatment unit, which coincides with the specific Current Procedural Terminology (CPT) and HCFA Common Procedure Coding System (HCPCS) procedure code descriptions. (Refer to Section IV of this handbook for information about Medicaid procedure codes.) Payment for treatment less than the procedure code unit per session is prorated. Additional units are paid only when a full unit of service is actually provided. Refer to Appendix 4 of this handbook for specific procedure codes and treatment units.

Facility Overhead Costs

Payment for direct and associated overhead costs is included in the payment for each treatment unit.

Provider Responsibilities

Specific responsibilities as a certified provider are stated in Section IV of Part A, the all-provider handbook. Refer to Section IV of Part A, the all-provider handbook, for information about the following:

- ✓ Fair treatment of the recipient.
- ✓ Maintenance of records.
- ✓ Recipient requests for noncovered services.
- ✓ Services rendered to a recipient during periods of retroactive eligibility.
- ✓ Grounds for provider sanctions.
- ✓ Additional state and federal requirements.

C. Recipient Information

Verifying Recipient Eligibility

Eligible recipients receive identification cards monthly that are valid through the end of the month issued. The identification cards include the recipient's name, date of birth, 10-digit identification number, medical status code, and, when applicable, an indicator of health insurance, HMO, and Medicare coverage.

Note: Check the recipient's identification card *before* providing service to determine recipient eligibility and any limitations to their coverage.

Section V of Part A, the all-provider handbook, provides detailed information about Medicaid eligibility, identification cards, temporary cards, restricted cards, and eligibility verification. *Review* Section V of Part A, the all-provider handbook, *before* rendering services. A sample identification card is in Appendix 7 of Part A, the all-provider handbook.

Copayment

Except as noted below, all recipients are responsible for paying part of the costs involved in obtaining physical therapy services. Refer to Appendix 4 of this handbook for procedure codes and their applicable copayment amounts.

Copayment exemptions include the following:

- ✓ Emergency services.
- ✓ Services provided to nursing home residents.
- ✓ Services provided to recipients under 18 years of age.
- ✓ Services provided to a pregnant woman if the services are pregnancy-related.

C. Recipient Information (continued)

- ✓ Services covered by Medicaid-contracted managed care programs to enrollees of the managed care program.
- ✓ Family planning services and related supplies.

Providers must make a reasonable attempt to collect copayment from the recipient. Providers are not allowed, at their discretion, to waive the recipient copayment requirement. The provider cannot deny a service to a recipient who fails to make a copayment.

The fiscal agent automatically deducts applicable copayment amounts from payments allowed by Wisconsin Medicaid. Do not reduce the billed amount of the claim by the amount of recipient copayment.

No copayment is deducted after the first 30 hours or $1,500 of services per calendar year.

Recipients Enrolled in Managed Care Programs

Recipients enrolled in Medicaid-contracted managed care programs (including Medicaid Health Maintenance Organization, or HMOs) receive a yellow identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. Refer to Chapter 4 in the Wisconsin Medicaid Managed Care Guide's provider section for the HMO Medicaid ID codes.

Providers must check the recipient's current identification card for managed care program coverage before providing services. Wisconsin Medicaid denies claims submitted to the fiscal agent for services covered by Medicaid-contracted managed care programs. Physical therapy claims must be submitted to the managed care program.

For recipients enrolled in a Medicaid-contracted managed care program, the contract between the managed care program and certified provider establishes all conditions of payment and prior authorization for physical therapy services.

Managed care programs exclude physical, occupational, and speech therapy provided in the school from coverage under their program. Refer to Appendix 22 of Part A, the all-provider handbook, for more information.

Refer to Wisconsin Medicaid Managed Care Guide's provider section for additional information about managed care program noncovered services, emergency, services, and hospitalizations.

D. HealthCheck

HealthCheck is Medicaid's federally mandated program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). HealthCheck consists of a comprehensive screening of eligible recipients under the age of 21, which includes the following:

- ✓ Review of growth and development.
- ✓ Identification of potential physical or developmental problems.
- ✓ Preventive health education.
- ✓ Referral assistance to appropriate providers of service.

HealthCheck also includes targeted outreach and case management services to "at risk" children to ensure that these children have access to needed medical, social, and educational services.

D. HealthCheck (continued)

Note: Wisconsin Medicaid covers medically necessary physical therapy services under the physical therapy benefit. HealthCheck benefit services also must be medically necessary. A request for prior authorization of physical therapy services that is denied for lack of medical necessity under the physical therapy benefit generally is not approved under the HealthCheck benefit because both benefits use medical necessity as the same prior authorization criteria and requirement.

Wisconsin Medicaid considers requests for medically necessary physical therapy services (under the HealthCheck benefit) which are not specifically listed as covered services when all of the following conditions are met:

- ✓ The service requested is for an individual under 21 years of age.
- ✓ The service is medically necessary to correct or improve a condition or defect discovered during a HealthCheck/EPSDT screening.
- ✓ The service is one which is an allowable service under federal regulations.

All such services require prior authorization for payment. Refer to Section III of this handbook for prior authorization information.

Refer to Section IV of Part A, the all-provider handbook, for additional information on HealthCheck "Other Services."

E. School-Based Services (SBS) Benefit

Background

Provisions of 1995 Wisconsin Act 27, the biennial budget, established a School-Based Services (SBS) benefit. The benefit allows schools and cooperative educational services agencies (CESAs) to bill Wisconsin Medicaid for medically necessary services provided to Medicaid-eligible children under age 21 or for any school term during which the individual became 21 years old. This benefit became effective for dates of service on and after July 1, 1995.

Covered SBS Services

The following services are covered under the SBS benefit when they are identified in the child's Individualized Education Program (IEP) or Individualized Family Service Program (IFSP) and certain requirements are met:

1. Physical therapy.
2. Occupational therapy.
3. Speech, language, audiology, and hearing.
4. Nursing.
5. Psychological services, counseling, and social work.
6. Developmental testing and assessments when they result in an IEP/IFSP;
7. Transportation.
8. Durable medical equipment (DME) not covered under Medicaid's DME benefit.

E. School-Based Services Benefit (continued)

Certification for School-Based Services: Impact on Therapy Providers

Effective July 1, 1996, all services covered under the SBS benefit that are delivered at a school site must be billed under the school district's or CESA's SBS provider number. This includes services delivered by school and non-school employees (or CESA and non-CESA employees) who are under contract or arrangement with the school district or CESA to deliver services at the school site.

Services under the SBS benefit that are delivered at a school site may not be billed by individuals or groups with the following Medicaid certification that duplicates SBS certification:

- ✓ Physical therapy and therapy assistants.
- ✓ Rehabilitation agency.
- ✓ Therapy groups.
- ✓ Occupational therapy and therapy assistants.
- ✓ Speech and hearing clinics.
- ✓ Audiologists.
- ✓ Speech pathology/therapy.
- ✓ Transportation.
- ✓ Nurse practitioners.

Effective July 1, 1996, individual providers cannot be certified for the above duplicate service areas when a school, school district, or CESA is the provider's payee. School districts and CESAs are not eligible for new group certification for the above provider groups on and after July 1, 1996.

A. Introduction

As specified in HSS 107.16, Wis. Admin. Code, covered physical therapy services are defined as medically necessary evaluations, modalities, and procedures prescribed by a physician. Refer to HSS 101.03 (96m), Wis. Admin. Code, for the definition of "medically necessary." The services must be performed by one of the following:

- ✓ Certified PT.
- ✓ Certified physical therapy assistant (PTA) under the direct (on premise) supervision of a PT.
- ✓ Physical therapy aide for specific services and when specific supervisory requirements are met (refer to Section II-E of this handbook for more information).

Services that do not require the skills of a PT (e.g., nursing services, active treatment services, activity services, and caregiver services) are not covered.

B. Covered Services

Evaluations

An *evaluation* consists of one or more tests or measures used to assess a recipient's needs. Evaluations are not paid when provided by a PTA or physical therapy aide. Refer to Appendix 6 of this handbook for a listing of types of covered evaluation services.

Evaluation days are, from a prior authorization threshold standpoint, considered treatment days and are counted toward the 35 treatment days within a spell of illness.

Therapy Evaluations in Facilities for the Developmentally Disabled

In most situations, a full professional evaluation by a therapy professional is *not* required annually for residents in a Facility for the Developmentally Disabled (FDD). Federal regulations require that the comprehensive assessment is reviewed at least annually for each resident in a FDD or Intermediate Care Facility for the Mentally Retarded (ICF-MR). Federal regulations [Interpretive Guidelines - Intermediate Care Facilities for the Mentally Retarded; Health Care Financing Administration Federal Regulations: State Operations Manual 212 483.440 (c) (3) (v)] require the facility to assess developmental *areas*, but *not* by professional disciplines unless the functional assessment shows a need for a full professional evaluation.

A physical therapy evaluation by a therapy professional must specify the recipient's current level of functioning and include one of the following:

- ✓ Specific recommendations for a therapy program, including measurable treatment goals.
- ✓ Specific current recommendations for active treatment, including specific instructions for other treatment staff.

Therapy evaluations in FDDs are subject to the spell of illness (SOI), prior authorization, daily duration, and other limitations referred to under HSS 107.16, Wis. Admin. Code. This applies to comprehensive therapy evaluations by independent and rehabilitation agency providers.

Modality

A *modality* consists of a treatment involving physical therapy equipment or apparatus which does not require the PT's personal continuous attendance when in use, but does require setting up, frequent observations, and evaluation of the treated body part before and after treatment. Refer to Appendix 7 of this handbook for a list of modalities.

B. Covered Services (continued)

Procedure

A *procedure* consists of a treatment (with or without equipment or apparatus) which requires the PT's personal continuous attendance. Refer to Appendix 8 of this handbook for a list of covered procedures.

Electrical Stimulation

Electrical stimulation for pressure sore treatment is covered only for stages III and IV pressure sores. Services must be performed under a PT's direct supervision.

C. Plan of Care

As specified in HSS 107.16, Wis. Admin. Code, a physician must prescribe (sign and date) or co-sign orders for physical therapy services for Medicaid coverage of the service. Therapists may document a physician's verbal order and then obtain the physician's signature and date.

A plan of care must be established and reduced to written form. As specified in HSS 107.16 (3) (a) 2, Wis. Admin. Code, the physician must review the plan of care in consultation with the provider. Reviews must occur at intervals required by the severity of the recipient's condition, but at least every 90 days. The plan of care may become the prescription when signed and dated by the physician. The provider must retain the plan of care in the recipient's permanent record.

The plan of care must include all of the following:

- ✓ The type, amount, frequency, and duration of the therapy services.
- ✓ All evaluations or results of current status reports that justify the plan of care.
- ✓ The diagnosis, a functional evaluation, and anticipated goals.

Changes to the plan, per the attending physician's verbal orders, must be in writing and signed and dated by the physician and the therapy provider.

D. Daily Service Limitations

Ninety-Minute Daily Coverage Limitations

As specified in HSS 101.03 (96m) and HSS 107.02 (2) (b), Wis. Admin. Code, Wisconsin Medicaid does not cover physical therapy services beyond 90 minutes per day unless coverage of additional medically necessary treatment is requested and approved through the claims adjustment process (see next paragraph). This limit is based on the determination that physical therapy services in excess of 90 minutes per day generally exceeds the medically necessary, reasonable, and appropriate duration of physical therapy services.

If, under extraordinary circumstances, physical therapy treatment is necessary beyond the limitation of 90 minutes per day, coverage of additional treatment time may be requested by submitting an adjustment request form after the claim is paid. The specific medical reason for exceeding the 90-minute limitation must be documented on the adjustment request form. Refer to Section X and Appendices 27 and 27a of Part A, the all-provider handbook, for information on submitting an adjustment request.

Daily Unit of Service Limitation

Wisconsin Medicaid covers some procedure codes only a limited number of times a day. Refer to 'Daily Unit of Service Limit' in Appendix 4 of this handbook for specific limits.

E. Allowed Procedures for PTAs

PTAs may not perform some Medicaid procedures such as evaluations. Refer to Appendix 4 for the procedure codes PTAs may perform.

F. Physical Therapy Aide Services

As specified in HSS 107.16 (1) (e), Wis. Admin. Code, physical therapy aides must be trained in a manner appropriate to their job duties. Clinical services that exceed a physical therapy aide's competence, education, training, and experience are not payable. Physical therapy aide services must be provided under the direct, immediate, on-premise supervision of a PT. The PT-to-physical therapy aide ratio must be 1:1 for billable services, except as noted in the next two paragraphs.

As specified in HSS 107.16 (1) (e), Wis. Admin. Code, the Department of Health and Family Services (DHFS) may exempt a facility providing physical therapy services from the supervision requirement if it determines that direct, immediate, one-to-one supervision is not required for specific assignments which physical therapy aides are performing at that facility.

For example, facilities providing significant amounts of hydrotherapy may be eligible for an exemption for physical therapy aides who fill or clean tubs. If an exemption is granted, the DHFS indicates the specific physical therapy aide services for which the exemption is granted and sets a supervision ratio appropriate for those services. Refer to HSS 106.13, Wis. Admin. Code, for more details on waiver requirements.

Physical therapy aides are not paid directly for their services.

As specified in HSS 107.16 (1) (e), Wis. Admin. Code, the following physical therapy aide services may be provided:

- ✓ Performing simple activities required to prepare a recipient for treatment, assisting in the performance of treatment, or assisting at the conclusion of treatment (such as helping the recipient to dress or undress, transferring a recipient to or from a mat, and applying or removing orthopedic devices).
- ✓ Assembling and disassembling equipment and accessories in preparation for treatment or after treatment has taken place.
- ✓ Assisting with the use of equipment and performing simple modalities once the recipient's program has been established and the recipient's response to the equipment is highly predictable.
- ✓ Providing protective assistance during exercise, activities of daily living, and ambulation activities related to the development of strength and refinement of activity.

G. Spell of Illness (SOI)

Definition

As specified in HSS 107.16 (1) (2) (a) through (e), Wis. Admin. Code, a "spell of illness" is a documented condition in which a recipient has a loss of functional ability to perform daily living skills. This loss of functional ability may be caused by a new disease, injury, medical condition, or by increased severity of a pre-existing medical condition.

Documenting an SOI

As specified in HSS 107.16 (2) (c), Wis. Admin. Code, the provider must document an SOI in the patient's plan of care, including all of the following:

- ✓ Measurable evidence that the recipient has incurred a demonstrated functional loss of ability to perform daily living skills.
- ✓ Has the potential to achieve his/her previous level of functional ability.

G. **Spell of Illness (SOI)** (continued)

When an SOI Begins

An SOI begins with the first day of treatment or evaluation following the onset of a new disease, injury, medical condition, or increased severity of a pre-existing medical condition.

The Recipient's First SOI

A recipient's first SOI is the first time the recipient requires therapy in their lifetime.

Treatment Days Allowed Within an SOI

Up to 35 treatment days are allowed per SOI. The 35 treatment days include all of the following:

- ✓ Evaluations.
- ✓ Treatment days covered by Medicare or health insurance.
- ✓ Treatment days provided by another provider, in any outpatient setting.

Unused treatment days from one SOI cannot be carried over into a new SOI. When a new authorized SOI occurs within the current SOI, the old (current) SOI stops, and a new SOI begins. The new authorized SOI has 35 treatment days. Prior authorization must be obtained for continued physical therapy services beyond the SOI.

When an SOI Ends

An SOI ends when the recipient's condition improves so that the services of a PT are no longer required or after 35 treatment days, whichever comes first.

Approval Process for an SOI

The recipient's first SOI in their lifetime does not need prior approval for payment of medically necessary services. After the first SOI, all additional SOIs require approval for payment by submitting a "Prior Authorization Spell of Illness Attachment" (PA/SOIA) and "Prior Authorization Request Form" (PA/RF) as soon as possible before billing for services.

Appendices 11 through 13 of this handbook contain instructions for submitting documentation for second and subsequent SOIs. The "Spell of Illness Guide" in Appendix 13 of this handbook further clarifies the SOI procedure.

Approval Criteria for a New SOI

As specified in HSS 107.16 (2) (a), (b), and (c), Wis. Admin. Code, to consider a condition as a new SOI, recipients must display the potential to reachieve the previously attained level of independence exhibited immediately before the onset of the SOI.

The following conditions may justify a new SOI:

- ✓ An acute onset of a new disease, injury, or condition such as one of the following:
  - → Neuromuscular dysfunction, including stroke-hemiparesis, multiple sclerosis, Parkinson's disease, and diabetic neuropathy.
  - → Musculoskeletal dysfunction, including fracture, amputation, strains and sprains, and complications associated with surgical procedures.
  - → Problems and complications associated with physiologic dysfunction, including severe pain, vascular conditions, and cardio-pulmonary conditions.

G. Spell of Illness (SOI) (continued)

- ✓ An exacerbation of a pre-existing condition, including but not limited to the following, which requires physical therapy intervention on an intensive basis such as one of the following:
  - → Multiple sclerosis.
  - → Rheumatoid arthritis.
  - → Parkinson's disease.
- ✓ A regression in the recipient's condition, due to a lack of physical therapy, as indicated by a decrease of functional ability, strength, mobility, or motion.

Services in Excess of 35 Treatment Days per SOI
Prior authorization is required for physical therapy services in excess of 35 treatment days for conditions that do not qualify for a new SOI.

H. Additional Requirements

Coverage of Treatment for Conditions That Never Qualify for an SOI
Certain conditions never qualify for an SOI such as decubitus ulcers and mental retardation.

For conditions that do not qualify for an SOI and for certain other procedures, prior authorization is required starting with the first day of treatment. Refer to Section III of this handbook for more information.

Co-Treatment (Interdisciplinary Treatment)
Co-treatment is covered only when medically necessary. Co-treatment is simultaneous treatment by two different therapy providers at the same time period, (e.g., by speech pathology and occupational therapy, or physical therapy and occupational therapy). Co-treatment may be requested when the unique treatment approach offered by multiple therapies during the same treatment session is medically necessary to optimize the recipient's rehabilitation. Refer to Section III of this handbook for more information.

Duplicate Services
As specified in HSS 101.03 (96m), Wis. Admin. Code, Wisconsin Medicaid does not cover duplicate services provided to recipients who have received physical therapy services from another certified provider. Before beginning evaluations or therapy, providers are advised to request prior authorization. For example, Wisconsin Medicaid may deny payment when another provider had a valid prior authorization for therapy services or when prior payment for physical therapy services has been received by another provider under a recipient's first or subsequent SOI.

Preventive/Maintenance Therapy Services
As specified in HSS 107.16 (3) (c), Wis. Admin. Code, Wisconsin Medicaid covers preventive/maintenance therapy services when one or more of the following conditions are met:

- ✓ The skills and training of a therapist are required to execute the entire preventive and maintenance program (e.g., there is no one else qualified to provide the level of care required).
- ✓ The specialized knowledge and judgment of a PT are required to establish and monitor the therapy program including the following:

H. Additional Requirements (continued)

- → The initial evaluation.
- → The design of the appropriate program.
- → The instruction of nursing personnel, family, caregiver, or recipient.
- → The required re-evaluations.

✓ The nursing personnel cannot handle the recipient safely and effectively due to the severity or complexity of the recipient's condition.

I. Durable Medical Equipment (DME) and Disposable Medical Supplies (DMS)

Durable medical equipment (DME) are medically necessary devices that can withstand repeated use. DME primarily serve a medical purpose and are generally not useful to a person without an illness or injury. All items must be appropriate for use in the recipient's place of residence.

DME are covered only when prescribed by a physician and listed as covered services in the Wisconsin DME Index for therapy providers. Refer to the DME and DMS handbook (Part N) for more information.

Wisconsin Medicaid may cover medically necessary DMS used during the course of treatment. Refer to the DMS Index for a list of covered DMS.

J. Communication with Other Medicaid Providers

When a recipient receives similar Medicaid services from therapists and other providers, these providers *must* communicate with each other for the following reasons:

- ✓ To ensure service coordination.
- ✓ To avoid duplication of services.
- ✓ To facilitate continuity of care.

Note: Other Medicaid providers are Medicaid HMOs and fee-for-service providers including other therapists, school-based services (SBS) providers, physician clinics, rehabilitation agencies, local health departments, community mental health agencies, tribal health agencies, and home care agencies.

When a recipient receives services from both SBS and non-SBS therapists, documented communication must occur at least annually. The communication must be documented in the recipient's medical records.

Note: SBS providers are required to cooperate with Medicaid fee-for-service providers who request copies of the child's IEP/IFSP or components of the multi-disciplinary team (M-team) evaluation.

K. Noncovered Services

As specified in HSS 107.16 (4), Wis. Admin. Code, Wisconsin Medicaid does not cover the following physical therapy services:

- ✓ Services related to activities for the general good and welfare of recipients include the following:
  - → General exercises to promote overall fitness and flexibility.
  - → Activities to provide diversion or general motivation.
- ✓ Those services that can be performed by restorative nursing, as specified in HSS 132.60 (1) (b) through (d), Wis. Admin. Code.

K. Noncovered Services (continued)

- ✓ Activities such as end-of-the-day clean-up time, transportation time, consultations and required paper reports (these are considered components of the provider's overhead costs and are not separately reimbursable).
- ✓ Group physical therapy services.
- ✓ Activities performed by a physical therapy aide including the following:
  - → Interpretation of physician referrals.
  - → Patient evaluation.
  - → Evaluation of procedures.
  - → Initiation or adjustment of treatment.
  - → Assumption of responsibility for planning recipient care.
  - → Making entries in recipient records.

As specified in HSS 107.02 (2), Wis. Admin. Code, services which require prior authorization but have not been approved are noncovered services.

As specified in HSS 101.03 (96m), Wis. Admin. Code, services determined by Wisconsin Medicaid as not medically necessary and/or experimental are noncovered services. This includes the following noncovered services:

- ✓ *Facilitated Communication (FC)* - This service is noted as experimental by the American Speech-Language-Hearing Association in ASHA, March 1995. The American Psychological Association, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and the American Association on Mental Retardation concur in policy statements developed in 1993 and 1994.
- ✓ *Auditory Integration Therapy (AIT)* - This service is noted as experimental by the American Speech-Language-Hearing Association in ASHA, November 1994, and the American Academy of Audiology in Audiology Today, July-August 1993.

As specified in HSS 107.16, Wis. Admin. Code, services that can be performed by nursing, active treatment, activity, and caregiver services are noncovered services under Medicaid's therapy benefit.

A. General Requirements

According to HSS 107.02 (3), Wis. Admin. Code, Wisconsin Medicaid requires prior authorization for certain services for the following reasons:

- ✓ Safeguard against unnecessary or inappropriate care and services.
- ✓ Safeguard against excess payment.
- ✓ Assess the quality and timeliness of services.
- ✓ Determine if less expensive alternative care, services, or supplies are usable.
- ✓ Promote the most effective and appropriate use of available services and facilities.
- ✓ Curtail misuse practices of providers and recipients.

Providers need prior authorization for certain specified services *before* delivery unless the service is an emergency. Payment is not made for services provided either before the grant date or after the expiration date indicated on the approved prior authorization request form. If the provider provides a service which requires prior authorization without first obtaining prior authorization, the *provider* is responsible for the cost of the service.

Prior authorization does not guarantee payment. Provider eligibility, recipient eligibility, and medical status on the date of service, and all other Medicaid requirements must be met before the claim is paid.

B. Services Requiring Prior Authorization

When Wisconsin Medicaid Requires Prior Authorization

Wisconsin Medicaid applies the same prior authorization requirements for all therapy providers:

1. Wisconsin Medicaid requires prior authorization for therapy services received from any provider in the recipient's lifetime in excess of 35 days per spell of illness (SOI) (HSS 107.16 (2), HSS 107.17 (2), and HSS 107.18 (2), Wis. Admin. Code).
2. For conditions that do not qualify for an SOI, Wisconsin Medicaid requires prior authorization starting with the first day of treatment.

   Examples include:

   - ✓ Decubitus ulcers.
   - ✓ Mental retardation.
   - ✓ Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing therapeutic services) with or without speech processor programming.
   - ✓ Modification of voice prosthetic or augmentative alternative communication device to supplement oral speech.
3. Wisconsin Medicaid also requires prior authorization starting with the first day of treatment for other circumstances including:

   - ✓ Co-treatment (interdisciplinary treatment).
   - ✓ Procedures shown as unlisted (non-specific) procedures as identified in Medicaid therapy publications.

B. **Services Requiring Prior Authorization** (continued)

Requirements for Electrical Stimulation as Treatment for Decubitus Ulcers

Decubitus ulcers do not qualify as an SOI. When requesting prior authorization for electrical stimulation as treatment for decubitus ulcers, request the service as a manual electrical stimulation procedure. Payment is made only for the face-to-face time that the PT is in attendance.

The prior authorization request must include all of the following documentation:

- ✓ The character, size, etc., of the pressure sore.
- ✓ Weekly measurements.
- ✓ Weekly percentage change in size or healing.
- ✓ The need for additional time for dressing changes or preparation time.

Prior authorization for continuing treatment is considered if formation of granulation tissue or a 25 percent reduction in area has occurred within 45 treatment days. Documentation of nursing protocols, positioning recommendations, and dietary involvement is required when this rapid improvement has not occurred within 45 days.

Co-Treatment (Interdisciplinary Treatment)

All co-treatment requires prior authorization. Each provider involved in co-treatment must complete a separate prior authorization request that identifies the other co-treatment provider and documents the medical necessity of co-treatment. Refer to Section II of this handbook for additional information on covered services.

Co-treatment is approved *only under extraordinary circumstances*. Requests for co-treatment must include documentation justifying why individual treatment from a therapist does not provide maximum benefit to the recipient and why two different kinds of therapy (treating simultaneously) are required. Wisconsin Medicaid recognizes that physical therapy, occupational therapy, and speech pathology each provide a unique approach to the individual's treatment. BHCF medical consultants review all prior authorization requests for co-treatment.

Other Circumstances

Providers should request prior authorization for all services provided to recipients who currently receive, or have previously received, physical therapy services from another certified provider to avoid denial for duplication of services. For example, payment is denied when another provider has a valid prior authorization for therapy services or when payment for physical therapy services is received by another provider under a recipient's first or subsequent SOI.

Physical Therapy Services Provided by Outpatient Hospital Facilities and Home Health Agencies

Prior authorization requirements *in this section* do not apply to *onsite* hospital services and home health agencies. Hospital *offsite* services follow prior authorization and other requirements in this handbook. Refer to the hospital handbook (Part F) for more information about other requirements beyond prior authorization. Physical therapy services provided by a home health agency are subject to other prior authorization requirements under HSS 107.11 (3), Wis. Admin. Code. Refer to the home health handbook (Part L, Division II) for more information about home health physical therapy services.

C. General Prior Authorization Requirements

The following are general prior authorization requirements for physical therapy services:

- ✓ The prior authorization request form must be complete and must contain sufficient information to clearly describe the medical necessity of the services.
- ✓ The services must comply with all state and federal regulations.
- ✓ The attachments, if submitted with the prior authorization request, must have the current date, recipient's name and identification number on each page, and be stapled to the prior authorization forms. Attachments may only supplement the information requested on the forms. The attachments *are not* a replacement for the prior authorization request forms.

Refer to Appendices 9, 9a, 10, and 10a of this handbook for more information.

D. Other Limitations

As specified in HSS 107.16 (3) (e), Wis. Admin. Code, extension of therapy services (e.g., additional therapy services) is not approved beyond the 35 treatment-day prior authorization threshold per SOI in any of the following circumstances:

- ✓ The recipient shows no progress toward meeting or maintaining established and measurable treatment goals over a six-month period. Or, the recipient shows no ability within six months to carry over abilities gained from treatment in a facility to the recipient's home.
- ✓ The recipient's chronological or developmental age, way of life, or home situation, indicates the stated goals are not appropriate for the recipient or serve no functional or maintenance purposes.
- ✓ The recipient has achieved independence in daily activities or can be supervised and assisted by restorative nursing personnel.
- ✓ The evaluation indicates the recipient's abilities are functional for the recipient's present way of life.
- ✓ The recipient shows no motivation, interest, or desire to participate in therapy, which may be for reasons of an overriding severe emotional disturbance.
- ✓ Other therapies are providing sufficient services to meet the recipient's functioning needs. Or, the procedures are one of the following:
  - → Not medical in nature.
  - → Experimental or research.
  - → Noncovered services.
  - → Determined by Wisconsin Medicaid to be medically unnecessary.

E. Completion of Prior Authorization Request Form (PA/RF) and Prior Authorization Therapy Attachment Form (PA/TA)

- ✓ The prior authorization request form must be filled out completely (i.e., all sections completed). The request and attached documents must include the following:
- ✓ The request must be accompanied by a physician's signature (a copy of the physician's order sheet dated within 90 days of its receipt by the fiscal agent indicating the physician's signature is acceptable). If the required documentation is missing from the request form, the request is returned to the provider for the missing information.

E. Completion of Prior Authorization Request Form (PA/RF) and Prior Authorization Therapy Attachment Form (PA/TA) (continued)

- ✓ A written report of the evaluation results and recommendations must be attached to the prior authorization request.
- ✓ The treatment plan must contain specific measurable goals including written instructions for follow-through or carryover by the recipient and/or caregiver. Carryover or follow-through is to be realistically achievable by the recipient and/or caregiver both at the place of residence for a recipient and other programs (e.g., in a facility for the developmentally disabled, nursing home, sheltered workshop, etc.). If carryover is not possible within six months of initiating treatment, continued authorization per the Wisconsin Administrative Code may not be approved.
- ✓ Progress statements must include information relating to progress in motor, sensory integrative and cognitive areas, and performance of independent living/ functional skills. Progress statements must be specific, objective, and measurable.
- ✓ If therapy is being requested for a school-age child *outside of* or *in addition* to school system therapy, the following must be included:
  - → A copy of the therapy IEP and the comprehensive therapy evaluation contained in the M-Team Report must be attached to the prior authorization request for the purpose of coordination and integration of the educational and medical needs of the child.
  - → If no therapy IEP or IEP M-Team therapy evaluation exists, information justifying the reason for the absence of school therapy must be submitted.
  - → Documentation substantiating the medical necessity of proposed therapy and the procedure for coordinating the treatment plan between therapists must be submitted.
- ✓ If therapy is requested for a recipient in a facility for the developmentally disabled (FDD), a copy of the Interdisciplinary Program Plan (IPP) must be attached to the prior authorization request to document coordination and integration of the active treatment and medical care plan of the recipient.
- ✓ Indicate the requested start date for therapy services to the right of element 24 on the PA/RF form.

F. Modifiers

Medicaid Modifier for Physical Therapy Procedure Codes

PTs, rehabilitation agencies, and therapy groups must add modifiers when requesting prior authorization for *all* physical therapy services.

Modifiers allow therapists and Wisconsin Medicaid to distinguish between physical and occupational therapy services with identical procedure codes. The modifier for physical therapy procedure codes is "PT."

How to Request Prior Authorization Using Modifiers

Enter the "PT" modifier on the PA/RF, in addition to all the other required elements, for physical therapy services under the new coding structure.

Refer to Appendices 9 and 9a for a PA/RF claim form sample and PA/RF completion instructions.

F. Modifiers (continued)

How to Request a New Spell of Illness (SOI) Using Modifiers

Include elements 14-19 on the PA/RF when requesting approval of a new SOI for physical therapy services under the new coding structure. This is in addition to all other required elements on the PA/RF. Refer to Appendices 11 and 11a for a PA/RF SOI sample and completion instructions.

SOIs authorized under deleted codes are not paid for dates of service after December 31, 1995.

You must amend PA/RFs with a Prior Authorization Spell of Illness Attachment (PA/SOIA) for dates of service after December 31, 1995. Amend the PA/RF by using the new coding structure and adding PA/RF elements 14 - 19 or complete a prior authorization request under the new coding structure. Refer to Appendices 12 and 12a for a PA/SOIA sample and completion instructions.

G. Additional Information Relating to Prior Authorization

Section VIII of Part A, the all-provider handbook, identifies procedures for obtaining prior authorization including emergency situations, appeal procedures, transferring authorization, supporting materials, retroactive authorization, recipient loss of eligibility midway in treatment, and prior authorization for out-of-state providers.

Multiple Providers

If more than one physical therapy provider from different agencies requests dual-treatment for one recipient, each provider must complete a separate PA/RF. The BHCF processes the requests *at the same time*. In addition to completion of the required prior authorization elements, include the following information:

- ✓ The reason for the dual-certification.
- ✓ The specific days of the week each provider administers the service.
- ✓ The procedure for the coordination of the treatment plan.

Change of Provider

An approved prior authorization may be transferred by the fiscal agent from the provider who obtained the approved prior authorization to another provider. The transfer may occur when medically necessary and when new ownership of a provider or a change in the billing provider number occurs. In all other circumstances when a recipient goes to a new provider, a new prior authorization must be requested.

The provider requesting transfer of the prior authorization must send all of the following to the fiscal agent:

- ✓ A copy of the current PA/RF.
- ✓ A new PA/RF which is *completely* filled out and indicates the "new" provider's name and provider number.
- ✓ A cover letter attached to the packet of PA/RFs that the provider sends to the fiscal agent. The cover letter must include the following information:
  - → The specific reason for the change of provider.
  - → The previous provider's name.

G. Additional Information Relating to Prior Authorization (continued)

- ➔ The new provider's name and provider number.
- ➔ The effective date of the transfer.

Providers must observe professional courtesy by sharing information for administrative purposes. The expiration date of the current prior authorization and the grant date of the new prior authorization are based on the effective date in the cover letter.

Review of Prior Authorization Decisions

When a provider disagrees with a prior authorization disposition, the provider may request an informal review by one of several methods:

- ✓ If a prior authorization has been approved with modification, submit a letter to amend the therapy request. Include all information that supports the request. Call the fiscal agent therapy consultant, if appropriate, before submitting the amendment form to discuss the pertinent issues. If the amendment is approved, the approval date is the date when the amendment request is received by the fiscal agent. It must be received within two weeks of the date the prior authorization is signed by the consultant (process date) on the original PA/RF.
- ✓ If a prior authorization has been denied, providers may, if appropriate, call the fiscal agent consultant to discuss the decision. If the fiscal agent consultant changes the decision based on additional clarifying information, a new prior authorization must be submitted with the additional documentation the consultant requires to change the denial. This information must be submitted to the fiscal agent within two weeks of the process date on the denied PA/RF. This request may be backdated to the first fiscal agent receipt date of the original denied prior authorization when the grant date is requested and the denied request is referred to in writing.

If the consultant does not change the denial, the *recipient* has the right to appeal through the fair hearing process as instructed in the denial letter. Recipients are notified of the denial and their right to appeal in writing.

Amending Approved Prior Authorization Requests

When medically necessary, providers may request amendments of valid prior authorizations to change the frequency of treatment, the specific treatment codes, or the grant or expiration dates. Changes to the original prior authorization request are based on changes in the recipient's medical condition (i.e., necessary increases or decreases in frequency, a different array of treatment codes found in the plan of care or extending the expiration date).

Valid prior authorizations are not amended to accommodate vacations or leaves of absence by either the recipient or provider. Prior authorization expiration dates may be amended up to one month beyond the original expiration date. The amendments may be done if the services are medically necessary and will be discontinued after a brief extension of the therapy services. However, if therapy is continued, it is recommended that a new prior authorization be submitted rather than go through the amendment process.

Providers amending prior authorization requests must do all of the following:

- ✓ Write a letter to the fiscal agent requesting an amendment to the approved prior authorization.

G. Additional Information Relating to Prior Authorization (continued)

- ✓ In sufficient detail, describe the reason for the request so Wisconsin Medicaid can determine its medical necessity.
- ✓ Describe in detail the specific change requested.
- ✓ Attach a copy of the approved prior authorization.
- ✓ Attach supporting clinical documentation.

Send the amendment request to:

EDS
Attn: Prior Authorization, Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Amendment Request Approval Criteria
Amendment requests may be approved if the request is medically necessary under HSS 101 (96m), Wis. Admin. Code, submitted before the date of the requested change, and fully explained and documented in the request. Clinical documentation of the medical necessity amendment request is required.

Following is an example of an amendment request that may be approved:

- ✓ A brief (less than one month) extension of the original approved prior authorization is requested. The brief extension occurs only when the recipient's medical condition is reasonably anticipated to improve during the extension period such that similar services will not be medically necessary following the requested extension (i.e. the provider is not expected to submit a new prior authorization request for similar services following the extension).

Amendment Request Denial Criteria
Amendment requests are denied if they are not medically necessary.

Requests are denied for the following reasons:

- ✓ Solely for the convenience of the recipient, the recipient's family, or the provider.
- ✓ Not received before the date of the requested change.
- ✓ Extending an approved prior authorization expiration date when the recipient's medical condition changes significantly, requiring a new plan of care.
- ✓ where similar services are expected to be medically necessary following the expiration date of the original approved prior authorization.

Note: At the end of a possible extension period, providers must submit a new prior authorization request instead of requesting an extension if one of the following occurs:

- → The recipient's medical condition changes significantly requiring a new plan of care
- → Similar services are expected to be medically necessary.

G. Additional Information Relating to Prior Authorization (continued)

Obtaining Prior Authorization

Sample prior authorization request forms along with their completion and submittal instructions are in Appendices 9 through 13 of this handbook.

Send completed prior authorization request forms to:

EDS
Attn: Prior Authorization Unit - Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Order prior authorization request forms from:

EDS
Attn: Form Reorder
6406 Bridge Road
Madison, WI 53784-0003

Please specify the prior authorization form and number desired. Reordered forms are included with form shipments. Do not request prior authorization forms by telephone.

H. HealthCheck "Other Services"

Medically necessary services which are not otherwise covered by Wisconsin Medicaid may be covered if they are provided to a recipient under age 21 as a result of a HealthCheck examination.

To request prior authorization for HealthCheck "Other Services," do:

- ✓ Submit a PA/RF.
  - → Indicate on the PA/RF that the request is for HealthCheck "Other Services."
  - → Wisconsin Medicaid assigns a procedure code if the service is approved.
- ✓ Submit the Prior Authorization Therapy Attachment (PA/TA) which clarifies the service and medical necessity of the service with the PA/RF.
- ✓ Include a signed and dated statement by the HealthCheck screener or an indication that the recipient received a HealthCheck screen.

The screen must have been performed within one year of the date of fiscal agent receipt of the prior authorization request. Also, the service must be a covered service under federal regulations.

A. Coordination of Benefits

Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. If the recipient is covered under other health insurance (including Medicare), Wisconsin Medicaid pays that portion of the allowable cost remaining after exhausting all other health insurance sources. Refer to Section IX of Part A, the all-provider handbook, for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report."

B. Medicare/ Medicaid Dual Entitlement

Recipients covered under both Medicare and Wisconsin Medicaid are known as dual-entitlees. Claims for Medicare-covered services provided to dual-entitlees must be billed to Medicare *before* billing Wisconsin Medicaid.

If the service for a recipient is covered by Medicare, but Medicare denies the claim, indicate a Medicare disclaimer code on the HCFA 1500 claim form. Although services covered by Medicare do not require prior authorization, providers are strongly encouraged to obtain prior authorization for dual-entitlees either at the time of initial Medicare claim submission or following a postpayment reconsideration. This ensures Medicaid payment if Medicare denies coverage.

Therapy Crossovers Subject to Medicaid Payment Limitations

Payments on certain therapy crossover claims from Medicare for dual-entitlees are subject to Medicaid maximum allowable fees and rates. Refer to Section IX of Part A, the all-provider handbook, for more information.

C. QMB-Only Recipients

Qualified Medicare Beneficiary Only (QMB-only) and Qualified Medicare Beneficiary-Nursing Home (QMB-NH) recipients are only eligible for Medicaid payment of the coinsurance and the deductibles for Medicare-covered services. If services are denied by Medicare, they are *not* covered by Wisconsin Medicaid.

D. Referring Provider

Claims for physical therapy services require the referring provider's name and UPIN number in elements 17 and 17a of the HCFA 1500 claim form. Refer to Appendix 1b of this handbook for billing instructions.

E. Reimbursement Methodology

Maximum Allowable Fees Based on Relative Value Units (RVUs)

Medicaid maximum allowable fees for CPT-4 and HCPCS codes for physical therapy procedures are based on the national standard Medicare Relative Value Units (RVUs).

The resource-based relative value scale (RBRVS) assigns RVUs based on the complexity of procedures. The RBRVS takes into account the provider's work for each procedure, practice expenses, and liability insurance. The work component includes the physical and mental intensity used to perform the service, the time taken to perform the service, and the pre- and post-face-to-face work associated with a typical encounter.

The work RVUs for services are based on the expectation that the code's definition represents exactly how the service is furnished when billed to Wisconsin Medicaid.

F. Payment Methods

Conversion of Therapy Treatment Time to Medicaid Treatment Units for Billing Purposes

For dates of service on and after September 1, 1995, the treatment unit of service is defined by the procedure code description. For example, when the description includes the statement 'each 15 minutes,' then one treatment unit of service is 15 minutes. If the description does not specify a time, the entire procedure, per date of service, equals one treatment unit of service. Part of a unit may be billed by using a number with a decimal point. Refer to Appendix 5 of this handbook for conversion charts. (Use the conversion charts applicable to the date of service.)

F. Payment Methods (continued)

Bill Face-to-Face Treatment Time Only

Bill the face-to-face treatment time actually provided. For example, if the procedure code description references 15 minutes of direct treatment, the provider must have furnished 15 minutes of direct, face-to-face treatment to the individual recipient to bill one unit of service.

Activities Included in a Treatment Unit

Based on CPT code definitions, only time spent in face-to-face treatment services to the individual recipient may be included in a Medicaid treatment unit.

Examples of face-to-face treatment time include the following:

- ✓ Time to obtain and update a history with the recipient present.
- ✓ Performing evaluation tests and measures with the recipient present.
- ✓ Face-to-face delivery of the physical therapy service to the recipient.

Non-face-to-face time is not included in a treatment unit. Examples of non-face-to-face treatment time include the following:

- ✓ Time to review records, score evaluation tests, and measures.
- ✓ Communication with other professionals, staff, and caregivers.

Non-face-to-face time is included in the reimbursement for the face-to-face service, as described under "Payment Methods."

G. Daily Service Limitations

Ninety-Minute Daily Coverage Limitations

As specified in HSS 101.03 (96m) and HSS 107.02 (2) (b), Wis. Admin. Code, Wisconsin Medicaid does not cover physical therapy services beyond 90 minutes per day unless coverage of additional medically necessary treatment is requested and approved through the claims adjustment process (see the next paragraph). This limit is based on the determination that physical therapy services in excess of 90 minutes per day generally exceed the medically necessary, reasonable, and appropriate duration of physical therapy services.

If, under extraordinary circumstances, physical therapy treatment is necessary beyond the limitation of 90 minutes per day, coverage of additional treatment time may be requested by submitting an adjustment request form after the claim is paid. The specific medical reason for exceeding the 90-minute limitation must be documented on the adjustment request form. Refer to Section X and Appendices 27 and 27a of Part A, the all-provider handbook, for information on submitting an adjustment request.

Daily Unit of Service Limitation

Wisconsin Medicaid covers some procedure codes only a limited number of times a day. Refer to 'Daily Unit of Service Limit' in Appendix 4 of this handbook for specific limits.

H. Billed Amounts

Providers must bill their usual and customary charge for services provided. The usual and customary charge is the amount the provider charges for the same service when provided to a private-pay patient. For providers using a sliding fee scale for specific services, the usual and customary charge is the provider's charge for the service when provided to a private-pay patient. Providers may not discriminate against a Medicaid recipient by charging a higher fee for the service than is charged to a private-pay patient.

H. Billed Amounts (continued)

Do not reduce the billed amount by the amount of recipient copayment. The applicable copayment amount is automatically deducted from the Medicaid-allowed payment.

I. Claim Submission

Paperless Claim Submission

As an alternative to submission of paper claims, the fiscal agent can process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as paper claims. Providers submitting electronically usually reduce their claim submission errors. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Paper Claim Submission

Submit procedure codes for physical therapy services on the HCFA 1500 claim form. A sample HCFA 1500 claim form and completion instructions are in Appendices 1, 1a, and 1b of this handbook.

Procedure codes for physical therapy services submitted on any other paper form than the HCFA 1500 claim form are denied.

The HCFA 1500 claim form is not provided by Wisconsin Medicaid or the fiscal agent. Claim forms are available from many suppliers, including:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

Mail completed claims submitted for payment to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims

The fiscal agent must receive all claims for services rendered to eligible recipients within 365 days from the date of the service. This policy pertains to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals are in Section IX of Part A, the all-provider handbook.

J. Diagnosis Codes

All diagnoses must be from *the International Classification of Diseases, 9th Edition, Clinical Modifications* (ICD-9-CM) coding structure.

Claims received without the appropriate ICD-9-CM code are denied.

Order the complete ICD-9-CM code book by writing to the address in Appendix 3 of Part A, the all-provider handbook.

J. Diagnosis Codes (continued)

Providers must note the following diagnosis code restrictions:

- ✓ Do not use codes with an "E" prefix as the primary or sole diagnosis on the HCFA 1500 claim form.
- ✓ Codes with an "M" prefix are not acceptable on the HCFA 1500 claim form.

K. Medicaid Procedure Codes

All HCFA 1500 claim forms require HCFA Common Procedure Coding System (HCPCS) codes. Claims or adjustments received without the appropriate codes are denied.

Medicaid Physical Therapy Procedure Codes

Refer to Appendix 4 of this handbook for Medicaid HCPCS procedure codes for billing and prior authorization for dates of service on and after September 1, 1995. Wisconsin Medicaid will notify providers when Wisconsin Medicaid adopts changes to these procedure codes.

Refer to Appendix 4 of this handbook for procedure codes for billing physical therapy services for dates of service before September 1, 1995.

Billing Evaluation Services in Facilities for the Developmentally Disabled

Effective September 1, 1995, evaluation services in facilities for the developmentally disabled (FDD) use HCPCS comprehensive evaluation procedure codes. Refer to Appendix 4 of this handbook for HCPCS procedure codes.

L. Modifiers

How to Bill Using Modifiers

PTs, rehabilitation agencies, and therapy groups must add modifiers when billing for *all* physical therapy services.

Modifiers allow PTs and Wisconsin Medicaid to distinguish between physical and occupational therapy services with identical procedure codes. The modifier for physical therapy procedure codes is "PT."

Paper Claims Submission

Enter the "PT" modifier in element 24d on the HCFA 1500 claim form or the claim will deny.

Paperless Claim Submission

Enter the "PT" modifier immediately after the procedure code in field "M1," or the claim will deny.

For example, a PT bills procedure code 97119 (therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility). The PT enters the "PT" modifier in element 24d on the HCFA 1500 claim form.

M. Follow-up to Claim Submission

To ensure that your claim is not denied, complete the claim form using:

- ✓ The *same* prior authorization number that is on the PA/RF.
- ✓ The *same* modifier for the same procedure code that is on the PA/RF.

M. Follow-up to Claim Submission (continued)

Providers are responsible for initiating follow-up procedures on claims submitted to the fiscal agent. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Refer to Appendix 17, for a list of EOB codes (denial codes), how to avoid claim denials, and a sample Remittance and Status Report with EOB codes. The fiscal agent takes no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to the fiscal agent. Section X of Part A, the all-provider handbook, includes detailed information regarding the following:

- ✓ The Remittance and Status Report.
- ✓ Adjustments to paid claims.
- ✓ Return of overpayments.
- ✓ Duplicate payments.
- ✓ Denied claims.
- ✓ Good Faith claims filing procedures.

Refer to Appendix 14 of this handbook for helpful hints for working with Wisconsin Medicaid.